Commonwealth of Massachusetts, Department of Public Health, Division of Food and Drugs
305 South Street, Jamaica Plain, MA 02130-3515
Telephone 617 983-6700 Fax 617 524-8062

Application for Massachusetts Controlled Substances Registration for Ambulances

In Accordance with the Controlled Substances Act, M.G.L. Chapter 94C

A separate Massachusetts Controlled Substances Registration is required for each principal place of business, e.g., satellite station or place of garaging.

Please be sure to:

- Complete the application form
- Enclose check or money order for $300 made payable to "Commonwealth of Massachusetts"
- Enclose a copy of your hospital affiliation agreement and a copy of your department or service's drug security policies
- Sign and date the form at the bottom
- Mail to the address above

Incomplete applications will be returned and will cause a delay in receiving your MCSR. Do not send originals of any supporting documents. They will not be returned. Instead send photocopies.
For further information visit our Web site at http://www.mass.gov/dph/dcp

Application Type: (Please select one) ❑ New ❑ Renewal ❑ Amended Information

In the boxes below enter the requested information.				
1)) Applicant: (Ambulance Service Name)				
2)) Ambulance Location: (Applications that include a P.O. Box number without a street address cannot be processed.)				
3)) Corporate Address:				
4)) Telephone No.: ( ) area code				
5)) Federal Tax ID No.: (Required by M.G.L. c. 30A, s. 13A)				
6)) Massachusetts Controlled Substances Registration number (If possessed):				
7)) ALS License Number:				
8)) Ambulance Classification: (Please select one) ❑ Paramedic: Schedules II, IV, VI only ❑ Intermediate: Schedule VI only ❑ Basic: Epinephrine only Schedule VI includes all prescription drugs not in Schedules II – V.				
9)) Name and Address of hospital pharmacy supplying emergency medication:				
10))Total number at this location of:	a) All EMT's	b) Basic EMT's	c) Intermediate EMT's	d) Paramedic EMT's
11))Attach a list of all controlled substances in Schedules II, IV and VI that will be maintained by the ambulance service. Include the name, strength and quantity that will be maintained on the ambulance for each of these controlled substances.				

12))Describe the manner in which all controlled substances will be secured:
13))Describe how controlled substances will be replenished and how often:
14))Has the applicant ever been convicted of any violation of State or Federal law relating to the manufacture, possession, distribution or dispensing of controlled substances? ❑ Yes * ❑ No
15))Has any professional license or registration held by the applicant under any name or corporate name or legal entity been surrendered, revoked, suspended or denied or is such action pending? ❑ Yes * ❑ No
* If you answered "Yes" to Question No. 14) or No. 15), a letter must be attached setting forth circumstances of such action(s).

I hereby certify that the information on this application is true to the best of my knowledge, and that the applicant will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations promulgated by the Department of Public Health. I also certify, in accordance with M.G.L. c. 62C, s. 49A, that the applicant has to the best of my knowledge and belief filed all state tax returns and paid all state taxes required under law.
Signed under the pains and penalties of perjury.

Signature of authorized individual _____ Date _____

Print Name: _____

Title: _____

For Office Use Only	
Application approved by:	Comments:
Date:	